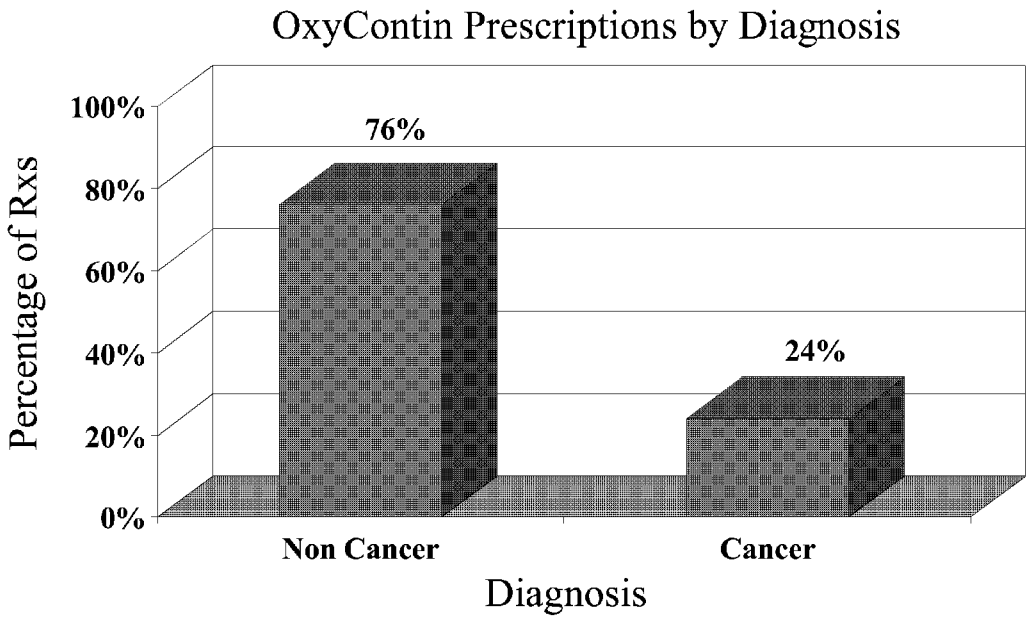
PSJ3
Exhibit 27

slide #1

Over $612 million in sales for 1999!

slide #2

OXYCONTIN® II
(OXYCODONE HCl CONTROLLED-RELEASE) TABLETS
10 mg 20 mg 40 mg 80 mg



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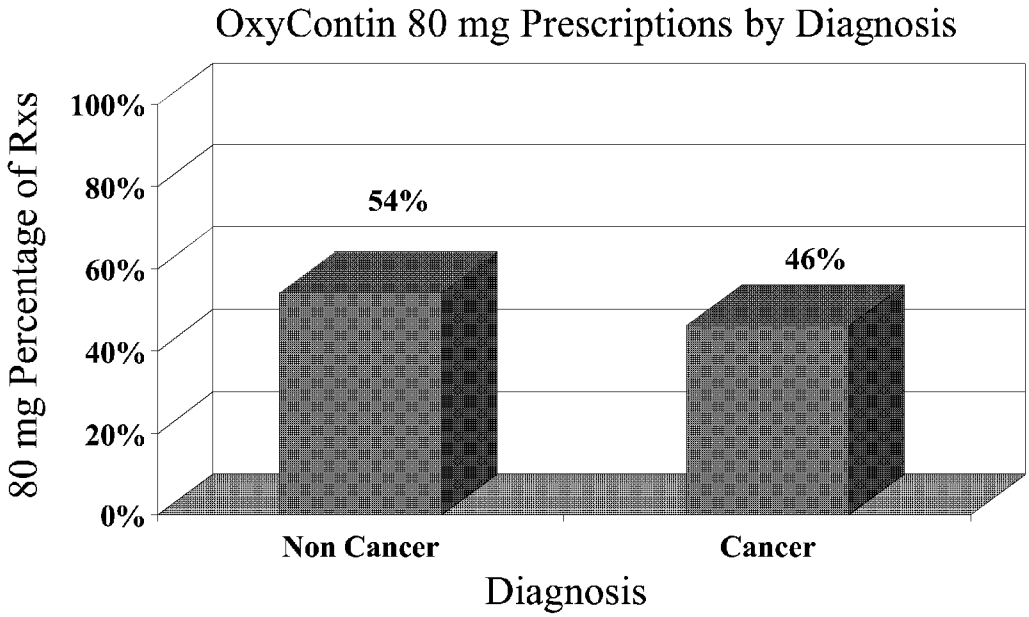
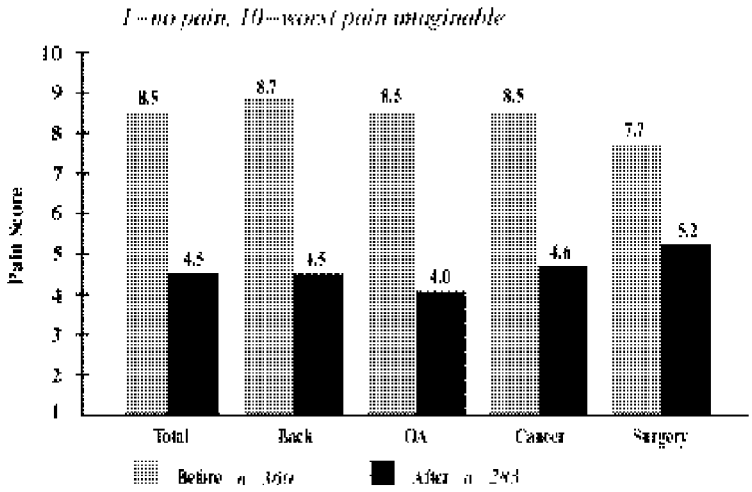
slide #3

OXYCONTIN® II
(OXYCODONE HCl CONTROLLED-RELEASE) TABLETS
10 mg 20 mg 40 mg 80 mg



slide #4

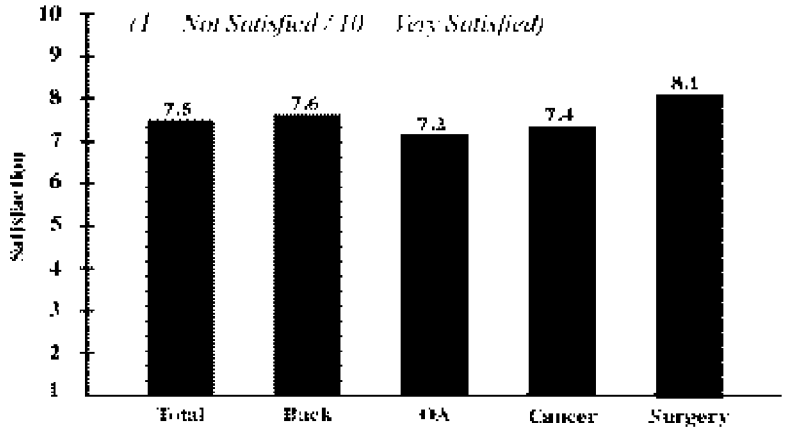
PAIN SEVERITY BEFORE AND AFTER TREATMENT WITH OXYCONTIN®(Oxycodone HCl Controlled-Release)Tablets



*Based on a survey of 393 OxyContin Patients.

slide #5

PATIENT SATISFACTION WITH OXYCONTIN



*Based on a survey of 393 OxyContin Patients.

slide #6

HAVE YOU SEEN OTHER PHYSICIANS FOR PAIN TREATMENT?

		Diagnosis			
	Total	**Back**	**OA**	**Cancer**	**Surgery**
	(393)	**(144)**	**(37)**	**(114)**	**(44)**
	%	**%**	**%**	**%**	**%**
Yes	**61**	67	68	49	48

*Based on a survey of 393 OxyContin Patients.

slide #7

66 different specialties use it

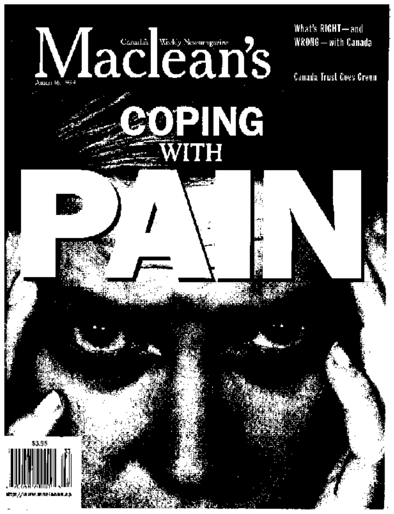
slide #8

- Public relations initiatives will:
  - Raise awareness of undertreated pain
  - Promote proper pain management
  - Make the whole pie bigger, not only for us but for our competition as well
  - Solidify Purdue as the market leader

slide #9

- National survey on the impact of pain

slide #10



When The Pain Refuses To Go Away

By Patricia Chisholm

From the age of 21, Pat Bauer learned to fear the brain-searing migraines that meant cancelled social engagements, time off work and hours in bed, waiting out the agony. She popped a dizzying array of pills—including powerful doses of morphine—tried natural therapies like herbs, and slept with an ice pack on her head. But there was never any real escape from what became a daily battle with pain. "Some days, I just wished I could drive into a truck and end it all," the 59-year-old BC Tel supervisor recalls.

Finally, a frustrated family doctor near Bauer's home in Celista, east of Kamloops, referred her to a multidisciplinary pain centre at St. Paul's Hospital in Vancouver. First, she was taken off heavy painkillers and put on Nardil, an older generation antidepressant, now sometimes used for severe headaches. Her daily regimen for the three weeks in April that she spent at the clinic included physiotherapy, occupational therapy, self-hypnosis and "positive affirmation"—using thoughts to combat the tension and low mood that can make chronic pain worse. Now, Bauer's headaches are far fewer in number and easier to control. "I need much less sleep and I have a lot more energy," she says. "It's so neat to see the world with a clear head. I feel as if I've been reborn."

Aching, stabbing, pounding, throbbing pain most people

Even when there is no physical cause, it is re

have experienced troubling physical discomfort that drags on for weeks or months. The vast majority recover with little or no medical intervention. But for a significant minority—an estimated five to 15 per cent of the population—chronic pain caused by migraines, low back pain and nerve damage among other ailments turns into lifelong burdens. The financial consequences are huge: at least $8 billion a year in Canada, including lost work time, insurance benefits and medical attention. "Treatment is very time consuming and resource intensive," notes Allan Gordon, a neurologist at Mount Sinai Hospital in Toronto who is helping set up a centre for the study of chronic pain at the University of Toronto. "It's only now that society is starting to recognize the extent of the problem."

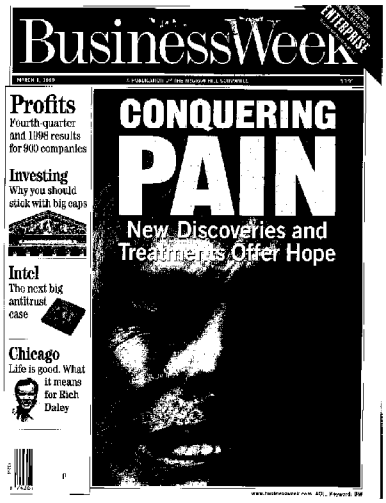
There are new reasons for hope, however. Almost every province now has at least one integrated pain clinic, like the one at St. Paul's, that brings together a wide range of disciplines, from anesthesia, to psychiatry and physiotherapy. Doctors are also gaining fresh insights from a new wave of epidemiological studies revealing who is at risk of chronic pain and which treatments work best. And while many doctors remain cautious about opioids—morphine-like drugs with addictive potential—some pain specialists say they should be used when all else fails because addiction is rare among well supervised patients (page 58).

For patients, though, a big problem still is one of the oldest—convincing others that they really are suffering. Many people with chronic pain that is not life-threatening look healthy. That can make getting treatment, benefits and moral support difficult. Patricia English, who lives in New Westminster, B.C., stopped working as an administrative assistant for the provincial government after experiencing acute headaches in 1993. In 1995, she was diagnosed with fibromyalgia. The disease, which has no known cause or cure, leaves sufferers feeling achy and tired all the time.

English, 42, says that on a "good" day she might be able to make the bed. On a bad day, she never leaves it. There are no good therapies for her condition: she takes Tylenol 3 for severe pain, but mostly she simply endures. So it was particularly hard when she was initially denied disability by her employer's insurer—she had to appeal to get the payments. "People are still more comfortable when it's something they can see," she says. "Even doctors."

Certainly, medical professionals remain divided about the psychological elements of many types of chronic pain. Ian Clarke, a Calgary anesthetist who specializes in chronic pain, says some studies estimate that as few as 10 per cent of patients show signs of a physical disease related to their pain. In Clarke's view, most chronic-pain sufferers are susceptible

slide #10a




Cover Story

Pain has an element of blank;
It cannot recollect
When it began or if there were
A time when it was not.

Emily Dickinson

Laura A. McManus is just one of the 50 million Americans who are partly or totally disabled by chronic pain. The 27-year-old from Mount Sinai, N.Y., has a congenital spine dysfunction that became debilitating when she pulled her back out at age 14. Her agony has persisted through seven spinal operations and a steady stream of ever more powerful drugs. "I've been on everything: Darvocet, Percocet, Vicodin, morphine in the pump, Dilaudid in the pump," she says. All of these narcotics eventually stopped working, and by 24 she had upped the dosage to the point where she was so drugged she could barely function. "I was borderline suicidal," she says.

Such misery is the bête noire of chronic-pain sufferers. The 20th century has brought amazing breakthroughs in almost every area of medicine save the one that afflicts everyone—pain. In the 100-plus years since Dickinson penned her sad poem, there have been only two dismal options. Patients could take aspirin and aspirin-like non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen and Naprosyn for mild-to-moderate pain or narcotics such as morphine and codeine for severe pain. Neither approach works for everyone or for every pain condition. Even when they do, NSAIDs and narcotics can have serious, even life-threatening, side effects ranging from stomach ulcers to addiction.

At last, though, chronic pain relief is becoming more than an oxymoron. After two decades of grueling research into the complex cellular processes that trigger pain, the first drugs custom-designed to block specific pain mechanisms are emerging from the labs. These new agents promise to revolutionize the treatment of pain by allowing doctors to relieve the suffering, regardless of the underlying cause. Best of all, the new drugs promise minimal side effects.

Such breakthroughs should translate into one of the largest drug markets of the next decade (page 110). "Let's face it: The first company that comes up with a drug for chronic pain

CONQUERING
PAIN

New discoveries and treatments offer hope

will take off like a rocket," says Dr. Mitchell Max, coordinator of pain research at the National Institutes of Health. Even with the suboptimal painkillers available today, the world market for analgesics is about $7.7 billion and growing 7% a year, estimates Credit Suisse First Boston Corp. The firm figures that drugs coming on the market this year and next should add $1.5 billion to that total by 2001.

Americans alone spend some $3 billion a year on over-the-counter analgesics, and a further $692 million is doled out for narcotics prescribed for pain. The buyers include 23 million arthritis

ILLUSTRATION BY MARSHALL ARISMAN

slide #11

slide #12

A Shift in the Treatment of Chronic Pain

With Laws as Shield, Doctors Are More Willing to Prescribe Drugs

By HOLCOMB B. NOBLE

After 40 years of debate among doctors, medical review boards and law-enforcement officials, state legislatures have begun passing laws to shield doctors from being prosecuted for prescribing powerful medications against intractable pain.

At the same time, leaders of major medical institutions said, a fundamental change has been occurring among doctors, who are now more willing to prescribe narcotics and other such medication to treat pain.

Last week, the agency that accredits most of the nation's health-care organizations adopted standards under which the organizations must "recognize the right of patients to appropriate assessment and management of pain." The agency, the Joint Commission on Accreditation of Healthcare Organizations, accredits about 20,000 hospitals, nursing homes and home-care agencies, which together provide some 96 percent of the nation's in-patient care.

"Unrelieved pain has enormous psychological effects on patients," said Dr. Dennis S. O'Leary, president of the joint commission, "and research shows that unrelieved pain can slow recovery, create burdens on patients and their families and increase costs of the health-care system. And we believe patients have an explicit right to effective assessment and management of existing pain."

In addition, half of the state medical boards in the nation have in recent years adopted model guidelines, written by the Federation of State Medical Boards, to protect doctors from losing their licenses for prescribing morphine and other narcotics, so long as they are given strictly for relieving pain.

For decades, doctors have been caught between complaints of undertreating pain and concern about being disciplined or prosecuted for being too aggressive.

Law-enforcement officials have been watchful for doctors who may supply narcotics to addicts for profit, or overprescribe drugs as a form of mercy killing or assisted suicide. At the same time, patients or their families have complained bitterly that they or their loved ones have often been left without relief to suffer needlessly for long periods.

In the early 80's, for example, Dr. Harvey Rose, a pain specialist in Sacramento, Calif., was accused by the California Medical Board of overprescribing pain medication. He succeeded in fighting the charge, but only after spending four years and $140,000. He then helped lead the efforts to make California one of the first states to enact the protective laws, in 1966, for doctors who use narcotic medications to treat chronic and intractable pain.

Doctors caught between duty and fear get some official support.

Relatively few criminal cases of overprescribing narcotics have been brought against doctors, "but the ones that were had a tremendously chilling effect," said Dr. Allen S. Lichter, past president of the American Society of Clinical Oncology. "Doctors just did not want to take the chance of getting caught up in that."

But the pendulum has swung. "Doctors and policy-makers both have finally come to say that treating chronic, intractable pain is one of the essential tasks of caring for a patient," Dr. Lichter said.

Nineteen states now have laws that protect doctors from prosecution by state and local law-enforcement agencies for overprescribing painkillers so long as the medications are needed to treat pain caused by medical disorders. The states, according to the National Conference of State Legislatures, are California, Colorado, Florida, Minnesota, Missouri, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Virginia, Washington, West Virginia and Wisconsin. A decade ago, no states had such protection.

Most of the changes have come in the last three years, and a dozen more states, along with the United States Senate, are considering similar legislation.

Besides the new legal protections, medical advances in recent years and broad cultural changes have also been factors in the change, said Dr. Kathleen Foley, a pain-management specialist at Memorial Sloan-Kettering Cancer Center in New York.

"There has been such an explosion in science in the understanding of pain systems," Dr. Foley said, "and because of this, along with the efforts of many brave people to persuade their colleagues to change their attitudes toward treating pain, the great barriers that have existed to proper pain control are finally coming down."

One barrier used to be the fear of creating narcotics addicts, noted Dr. Jane L. Dahl, a professor of medicine at the University of Wisconsin Medical School who was on the panel of the Federation of State Medical Boards that adopted the pain guidelines. But, Dr. Dahl said, "There is absolutely no data that show patients properly treated for severe pain with painkillers becoming addicted except for those with a history of drug abuse, and they have to be screened out."

Medication for severe, long-term pain usually includes opiates or a narcotic that in the correct dosage dulls pain and induces sleep but in overdoses can cause convulsions and death.

"What one must know is that when the medication is built up slowly over time, when the doses are gradually increased, a patient can tolerate levels high enough to relieve very severe pain," Dr. Dahl said, although she cautioned that the doctor, the patient or a relative of the patient must have some expertise in pain control.

Officials, doctors and researchers at cancer treatment centers, the National Institutes of Health, the American Medical Association, patient-support groups and researchers at several universities have been at the forefront to bring about the changes. They have built on the efforts of people like Dr. Elizabeth Kübler-Ross, who as a professor of medicine at the University of Chicago Medical School in the 1950's was virtually ostracized by fellow doctors for complaining that they routinely neglected patients once they became terminally ill and left them to die in pain.

But the medical establishment has been slow to change. Dr. Melvin H. Konner, an anthropologist at Emory University in Atlanta who is also a graduate of Harvard Medical School, said that as recently as the 1980's interns in university hospitals were routinely told to ignore the pain of sick or injured newborn babies because their brains were too undeveloped to experience it. "We now know that this is not so," Dr. Konner said.

Just last year, the Journal of the American Medical Association reported a Brown University study of 15,635 cancer patients in nursing homes, age 65 or older, showing that only 26 percent of those in pain were given any medication. And in 1995, the journal published a survey in which family members of one group of 4,301 conscious patients who died in hospitals reported that 50 percent of them were in moderate to severe pain in the last eight days of their life. Though some patients refuse medication, the percentage was regarded as far lower than the number of patients who want pain relief if given the choice.

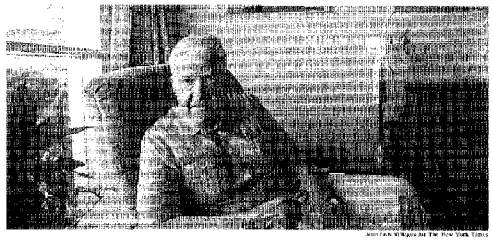
Despite the changes in law and medical board guidelines, pain treatment remains controversial. In Sacramento, Dr. Rose said he had to argue vigorously to get the right amount of medicine for his wife to relieve her pain as she was dying of cancer in 1994 — and then again last year for himself when he was recuperating from a quadruple bypass.

Last February, another Californian, Dr. Frank Fisher, was charged with three counts of murder in the deaths of three patients treated at his clinic in Redding. Dr. Fisher was jailed, unable to post the bail set at $1.5 million, to await trial. He said he treated a large number of patients, many of them poor people who had chronic, intractable pain but had been snubbed by other doctors. "I feel like I'm being punished for behaving in good conscience and for doing the right thing," he said.

But a spokesman for the California Attorney General's Office insisted that enough evidence had been presented at a preliminary hearing by other doctors who said "an inordinate amount of painkillers" had been prescribed to justify a trial. The prosecutor's concern was that, rather than treating real pain, the doctor was simply supplying drugs to those who abused them and who had no medical need.

A group of Dr. Fisher's patients came to his defense, including the husband of one of the alleged victims, who said she had had grave health problems and did not die from her medications. The head of the local county health center called Dr. Fisher's arrest "a disaster, like a natural disaster, like an earthquake," and said the county was suddenly left with hundreds of people who were unable to get the medication they needed.

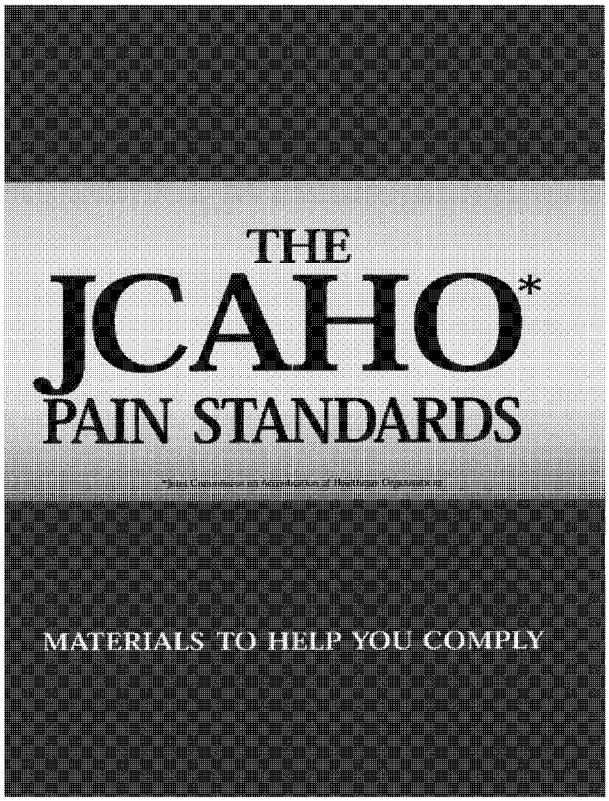
On July 16, the murder charges were dropped and Dr. Fisher was released after four months in jail, on the ground that there was insufficient evidence of an intent to kill. But the doctor is not free and clear: the three murder indictments were reduced to manslaughter.



Dr. Harvey Rose of Sacramento, Calif., who was accused of overprescribing pain medications in the 1980's, later led efforts to enact laws in California to protect doctors who prescribe drugs to treat chronic pain.

slide #13

slide #14



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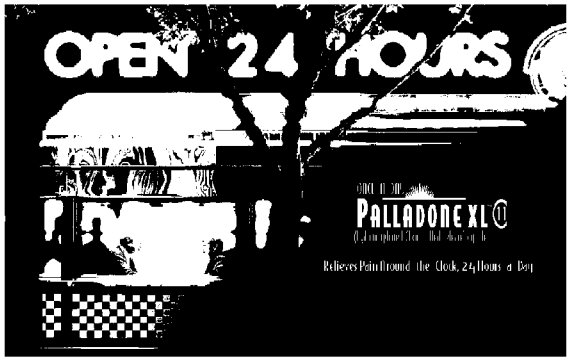

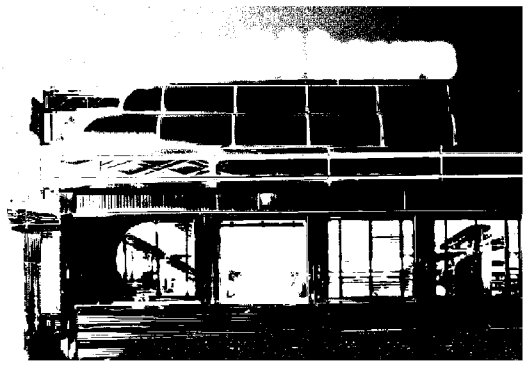

I know that the logo color has changed to blue, but I don't have that version.

Jane

slide #17

OXYCONTIN® II
(OXYCODONE HCl CONTROLLED-RELEASE) TABLETS
10 mg 20 mg 40 mg 80 mg

PDD8801320919

slide #18

- The Purdue pipeline includes products in these areas (aside from analgesia)
  - anesthesia
  - oncology with monoclonal antibodies

slide #19